

**INFLUENZA AND PNEUMOCOCCAL
VACCINE CONSENT FORM**

Client: _____

DOB (yyyy/mmm/dd): _____

HRN / MHSC: _____

PHIN#: _____

Addressograph/Place Label Here

Clinic Location: _____

Date: _____

A. PERSONAL INFORMATION:

Last Name	Given Names	Date of Birth	Gender
PHIN (9 digits)	MHSC # (6 digits)	Address	Phone Number

B. HEALTH INFORMATION:

- Are you well today? If no, describe _____ Yes No
- Do you have any allergies? Yes No
If yes, describe _____
- Have you ever had a serious reaction or condition following any vaccine? Yes No
If yes, describe _____
- Do you have any conditions that require medication or regular visits to your doctor? Yes No
If yes, describe _____

C. CONSENT:

I have read and understood the fact sheet(s) provided. I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

Check off which vaccine(s) you are consenting to be administered to the above named person:

-
- Influenza Vaccine
-
- Pneumococcal Vaccine

Please complete ONE of the following two options:

Consent by Client: Signature: _____ Date (yyyy/mmm/dd): _____	Consent by parent or legal decision maker: Printed Name: _____ Signature: _____ Relationship: _____ Date (yyyy/mmm/dd): _____
--	---

D. THE FOLLOWING SECTION IS TO BE COMPLETED BY AN IMMUNIZATION PROVIDER:

-
- Fact Sheet(s) reviewed
-
- Health history reviewed
-
- Questions addressed
-
- Information provided on reporting adverse events

Date y/m/d	Vaccine	Manufacturer	Lot #	Dose	Route	Site	Provider's Signature	Data Entry Initials
	Influenza							
	Pneu-P-23							

Notice: Information about the immunizations you or your child(ren) receive may be recorded in the provincial immunization registry. This registry allows your health care providers to find out what immunizations you or your child have had or need to have. Information collected in the provincial immunization registry may be used to produce immunization records, or notify you or your health care provider if a particular immunization has been missed. Manitoba Health, Seniors and Active Living may use the information to monitor how well different vaccines work in preventing disease. *The Personal Health Information Act* protects your information. You can have your personal health information hidden from view from health care providers. For more information, please contact your local public health office to speak with a public health nurse www.gov.mb.ca/health/publichealth/offices.html

INTERPRETER DECLARATION:

To the best of my knowledge, I accurately interpreted the contents of this form (sight translation, as applicable) AND/OR the related conversation(s) between _____ and _____
 Print name of person obtaining consent Print name of person providing consent

Interpreter Printed Name

Interpreter Signature

Language